IPDR6702				NORTH CAROLINA		PAGE:	1	
RUN DATE: 0	01/02/2006		IPRS (HECKWRITE SUMMARY REPORT				
				KWRITE DATE: 01/06/2006 INANCIAL PAYER: NCDMH				
		T	Γ	INANCIAL PAYER: NCDMH				
							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
	PROVIDER NAME	2020	DENTALO	DEGULETTON	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	0	0	*** NO DATA TO REPORT ***				
	H/DD/SAS							
		-	-					-
		0	0		0	0	0	0
3404904	WESTERN HIGHLAN	191	49	CLIENT ID NUMBER DOES NOT MATC				
	DS LME			H PATIENT NAME				
		8537	36	PROCEDURE IS NOT PAYABLE FOR Y	0	119	12186	12067
				OUR PROVIDER TYPE AND		119	12100	12007
				SPECIALTY IN ACCORDANCE TO MEN				
		8599	14	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404910	D2.000.000	8505	915	CLAIM DENIED DUE TO INSUFFICIE				-
	PATHWAYS			NT BUDGET				
		11	108	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE	0	1037	1249	211
		0510		ATTAL PRINTING CURVITABLE PRIVATE				
		8518	8	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
3404912	CATAWBA COUNTYM	11	108	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	ENTAL HEALT		l					
		8599	104	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	215	2679	2464
		 	 	BENEFIT PACKAGE.				
		21	3	DUPLICATE OF CLAIM-SYSTEM				
3404913	MECKLENBURG COM	11	437	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	ENTAL HEALT			2012				
		8599	69	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	67	585	988	403
			-	BENEFIT PACKAGE.				
		8933	40	ADTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
		-	 				 	
3404916	CROSSROADS BEHA	11	156	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	VIORAL HEAL	-	<u> </u>					
		8599	3	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	159	170	11
		-	 	BENEFIT PACKAGE.			 	
3404917	CENTERPOINT HUM	11	658	CLIENT NOT ELIGIBLE ON SERVICE DATE				
	AN SERVICES			2012				
		8599	70	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1	863	1524	661
			 	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8518	61	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR				
		ļ	 	FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
		-	 					-
3404918	ROCKINGHAM CO M	0	0	*** NO DATA TO REPORT ***				
	ENTAL HEALT	-	-					
			 					
		0	0		0	0	0	0
		-				<u> </u>		
			1	l .			I .	1

PROVIDER		HIGH DENIAL	NUMBER OF				TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EUBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404919	GUILFORD CO MEN	8599	108	DETAIL NOT COVERED BY COMBINAT				
	TAL HEALTHC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	35	DUPLICATE OF CLAIM-SYSTEM	37	245	3096	2851
	ļ							
		8931	27	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404920	ALAMANCE CASWEL	8505	3890	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	L AREA MH D			NT BUDGET				
			ļ					
		11	524	CLIENT NOT ELIGIBLE ON SERVICE	224	5011	10746	5735
	 			DATE		3011	10740	3/3.
			İ					
		8599	186	DETAIL NOT COVERED BY COMBINAT				
			ļ	ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404921		5312	3739	PRIOR AUTHORIZED DOLLARS EXCEE			-	
3404921	ORANGE PERSON C	5312	3739	DED DOLLARS EXCEE				
	HATHAM AREA		 					
	-	-	l					
	 	8599	146	DETAIL NOT COVERED BY COMBINAT	20	4322	7034	2712
				ION OF RECIPIENT, PROVIDER AND	20	4,522	,534	
				BENEFIT PACKAGE.				
		8505	137	CLAIM DENIED DUE TO INSUFFICIE				
				NT BUDGET				
3404922		21	3917	DUPLICATE OF CLAIM-SYSTEM				
3404522	THE DURHAM CENT	21	3317	DOFFICATE OF CLAIM-SISIEM				
	ER		ļ					
		27	3250	DIAGNOSIS CODE MISSING OR INVA	15	13674	26402	12728
		<u> </u>		LID. VERIFY AND ENTER THE				
				CORRECT DIAGNOSIS CODE AND SUB				
		8329	2783	CLAIM DENIED ATTENDING PROVIDE				
				R CANNOT BE THE SAME AS				
	ļ		ļ	THE IMA				
3404923		11	754	CLIENT NOT ELIGIBLE ON SERVICE				
3404923	FIVE COUNTY MH	111	/34	DATE				
	 			5612				
								
		21	188	DUPLICATE OF CLAIM-SYSTEM	0	1580	5659	4079
			[
		8599	170	DETAIL NOT COVERED BY COMBINAT				
			ļ	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
	ļ			BENEFIT PACKAGE.				
3404925	-	8599	655	DETAIL NOT COVERED BY COMBINAT				ļ
J40432J	SANDHILLS CENTE	0000		ION OF RECIPIENT, PROVIDER AND				
	R FOR MH/DD			BENEFIT PACKAGE.				
	-	 	l					
	 	8536	554	ATTENDING PROVIDER TYPE AND SP	47	2689	6993	4304
	<u> </u>		l	ECIALTY COMBINATION IS NOT	4/	2089	0393	4304
				VALID FOR SUBMITTED BILLING PR				l
		79	395	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				ļ
3404926	-	11	1828	CLIENT NOT ELIGIBLE ON SERVICE			-	
3404320	SOUTHEASTERN RE	11	1020	DATE				
	G MENTAL HL	ļ	l	DOLLA .				
	 	-	 				-	
		8599	60	DETAIL NOT COVERED BY COMBINAT	45	2065	3295	123
		1	 	ION OF RECIPIENT, PROVIDER AND	45	2065	3295	123
	 	<u> </u>	l	BENEFIT PACKAGE.				
								l
		5404	46	SEVERE DUPLICATE: SAME ATTO PR				
	1	I	l	OV/PCODE/TOS/DOS/MOD				
	,							

							TOTAL	TOTAL
PROVIDER NUMBER		HIGH DENIAL EOBS	NUMBER OF DENIALS		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404927	ļ	8505	842	CLAIM DENIED DUE TO INSUFFICIE				
3404327	CUMBERLAND CO M	6303	042	NT BUDGET				
	HC		ļ	NI BODGEI				
			 					
		11	77	CLIENT NOT ELIGIBLE ON SERVICE		976	2044	1068
	<u> </u>	 	 	DATE	°	370	2044	1000
	<u> </u>		 					
			İ					
		23	19	SERVICE REQUIRES PRIOR APPROVA				
				L				
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS	<u> </u>	ļ					
		0						
	 	10	ļ		0	0		0
			ļ					
3404930	JOHNSTON COUNTY	11	12	CLIENT NOT ELIGIBLE ON SERVICE				
	JOHNSTON COUNTY MNTL HLTHC		 	DATE				
	PARTA BAIRC	<u> </u>	t		†			l
			 		l			l
		10	4	DIAGNOSIS OR SERVICE INVALID F	0	16	27	11
				OR CLIENT AGE. VERIFY CID,	l	10	27	
	 		 	DIAGNOSIS, PROCEDURE CODE FOR				
								l
3404931	WAKE CO HUM SVC	8518	551	CLAIM DENIED, SUBMITTED BEYOND				
	BILLING OF			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
	<u> </u>		l		ļ			
		8599	318	DETAIL NOT COVERED BY COMBINAT	141	1465	18729	17264
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE				
				BENEFIT PACKAGE.				
		21	118	DUPLICATE OF CLAIM-SYSTEM				
	 	21	110	DUPLICATE OF CLAIM-SISTEM				
		-	 					
			 		l			
3404933	SOUTHEASTERN CT	8621	69	60 RESIDENTIAL LEVEL III TREAT	 			
	R FOR MH/DD	 	 	MENT RECEIVED, PA IS REQUIRED				
	I TOK MAY DO		-	FOR ADDITIONAL SERVICE.				
		 	†					
		8000	31	NO RATE AVAILABLE ON FILE TO P	1	149	2853	2704
				RICE THIS CLAIM DETAIL				
		11	20	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
			ļ					
3404934	ONSLOW CARTERET	11	123	CLIENT NOT ELIGIBLE ON SERVICE				
	BEHAV HEAL	1	1	DATE				
					ļ	ļ		
		8599	43	DETAIL NOT COVERED BY COMBINAT				
		8599	43	DETAIL NOT COVERED BY COMBINAT	2	219	1783	1564
		8599	43	ION OF RECIPIENT, PROVIDER AND	2	219	1783	1564
		8599	43	DETAIL NOT COURSED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	2	219	1783	1564
			43	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	2	219	1783	1564
		8599		ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OT A VALUE IPPS ATTENDING	2	219	1783	1564
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N	2	219	1783	1564
				ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2	219	1783	1564
3404935	WAYNE CO MENTAL			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OT A VALUE IPPS ATTENDING	2	219	1783	1564
3404935	WAYNE CO MENTAL HEALTH CTR			ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2	219	1783	1564
3404935				ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2	219	1783	1564
3404935		8534		ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2	219	1783	1564
3404935				ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2	219	1783	1564
3404935		8534		ION OF RECIPIENT, PROVIDER AND ERNEFIT PACKAGE SERVICE FACILITY LOCATION IS N OF A VALID IRFS ATTENDING PROVIDER, PLEASE VERIFY THE P	2			1564
	HEALTH CTR	0	0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE OF A VALID IPS ATTENDING PROVIDER, PLEASE VERIFY THE P *** NO DATA TO REPORT ***	2			1564
	HEALTH CTR WILSON-GREENE M	8534		ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OR A VALID IPPS ATTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTNC INELIGIBLE TO RECEIVE SE	2			1564
	HEALTH CTR	0	0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE OF A VALID IPS ATTENDING PROVIDER, PLEASE VERIFY THE P *** NO DATA TO REPORT ***	2			1564
	HEALTH CTR WILSON-GREENE M	0	0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OR A VALID IPPS ATTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTNC INELIGIBLE TO RECEIVE SE				1564
	HEALTH CTR WILSON-GREENE M	0 0 8931	0	ION OF RECIPIENT, PROVIDER AND ENREFIT PACKAGE. SERVICE PACILITY LOCATION IS N OT A VALID IRRS ATTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTHC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.		0	0	0
	HEALTH CTR WILSON-GREENE M	0	0 0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OF A VALID IRPS ATTENDING PROVIDER, PLEASE VERIFY THE F *** NO DATA TO REPORT *** ANTHO: INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	0		0	0
	HEALTH CTR WILSON-GREENE M	0 0 8931	0	ION OF RECIPIENT, PROVIDER AND ENREFIT PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICE PACKAGE. SERVICES IN IPR.S. PROCEDURE IN DEPARTMENT OF PACKAGE. PROCEDURE IN DEPARTMENT OF PACKAGE. SERVICES IN IPR.S.		0	0	0
	HEALTH CTR WILSON-GREENE M	0 0 8931	0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OF A VALID IRPS ATTENDING PROVIDER, PLEASE VERIFY THE F *** NO DATA TO REPORT *** ANTHO: INELIGIBLE TO RECEIVE SE RVICES IN IPRS.		0	0	0
	HEALTH CTR WILSON-GREENE M	0 0 8931	0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OF A VALID PREASTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTNC YNELIGIBLE TO RECEIVE SE RVICES IN IPRS. FROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SECIALTY IN ACCORDANCE TO MEN		0	0	0
	HEALTH CTR WILSON-GREENE M	0 0 0 8931 8537	0	ION OF RECIPIENT, PROVIDER AND ENNEFIT PACKAGE OF A VALID IRES ATTENDING PROVIDER. PLEASE VERIFY THE P *** NO DATA TO REPORT *** ANTHC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND DETAIL NOT COVERED BY COMBINAT		0	0	0
	HEALTH CTR WILSON-GREENE M	0 0 0 8931 8537	0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. SERVICE FACILITY LOCATION IS N OF A VALID PREASTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTNC YNELIGIBLE TO RECEIVE SE RVICES IN IPRS. FROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SECIALTY IN ACCORDANCE TO MEN		0	0	0
	HEALTH CTR WILSON-GREENE M	0 0 0 8931 8537	0	ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE SERVICE FACILITY LOCATION IS N OT A VALID INFRA ATTENDING PROVIDER. PLEASE VERIFY THE F *** NO DATA TO REPORT *** AMTHC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN DETAIL NOT RECUPIENT, PROVIDER AND		0	0	0

PROVIDER		HIGH DENIAL	NUMBER OF				TOTAL	TOTAL
NUMBER			DENIALS	DECORATE DE LOS	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
2404027	ļ	70		MUTO OPPUTOR TO NOW PAVARITE MO		<u> </u>		
3404937	EDGECOMBE NASH	79	123	THIS SERVICE IS NOT PAYABLE TO				
	MNTL HLTH C			YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
	ļ. <u></u>	ļ	ļ	PROVIDER TYPE AND SPECIALTY IN		<u> </u>		
				DUPLICATE OF CLAIM-SYSTEM				
		21	28	DUPLICATE OF CLAIM-SYSTEM	4	166	4078	3912
	ļ	<u> </u>						
			ļ					
		191	6	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404938	VGFW DBA RIVERS	10	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
	L	10	0			0		0
3404939	NEUSE MENTAL HE	11	55	CLIENT NOT ELIGIBLE ON SERVICE				
	ALTH CENTER			DATE				
			l					
		8599	23	DETAIL NOT COVERED BY COMBINAT	0	94	1880	1786
	ļ			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		191	9	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404941	PITT CO MH/DD/S	8599	49	DETAIL NOT COVERED BY COMBINAT				
	AS CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		120	23	CLIENT ID NUMBER MISSING OR IN	2	130	724	594
			l	VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
		191	19	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404942	ROANOKE CHOWANH	21	21	DUPLICATE OF CLAIM-SYSTEM				
	UMAN SERVIC							
		8931	3	AMTNC INELIGIBLE TO RECEIVE SE	4	30	591	561
				RVICES IN IPRS.				
		<u> </u>						
		8599	3	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
· · · · · · · · · · · · · · · · · · ·	<u> </u>			BENEFIT PACKAGE.				
3404943	ALBEMARLE MENTA	79	66	THIS SERVICE IS NOT PAYABLE TO				
· · · · · · · · · · · · · · · · · · ·	L HEALTH CE			YOUR SUBMITTED BILLING				
			1	PROVIDER TYPE AND SPECIALTY IN				
		11	61	CLIENT NOT ELIGIBLE ON SERVICE	55	250	1775	1525
				DATE				
			1					
		8931	35	AMTNC INELIGIBLE TO RECEIVE SE				
	<u> </u>	·	i	RVICES IN IPRS.				
3404944	EASTPOINTE HUMA	11	1164	CLIENT NOT ELIGIBLE ON SERVICE				
	N SERVICES			DATE				
 								
	,							
				DETAIL NOT COVERED BY COMBINAT	· · · · · · · · · · · · · · · · · · ·	1172	1179	7
		8599	P P					
		8599	,	ION OF RECIPIENT, PROVIDER AND				
		8599		ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8599						
			2	BENEFIT PACKAGE.				
		8599	2					
			2	BENEFIT PACKAGE.				
			2	BENEFIT PACKAGE.				
340.4946		21	2	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM				
3404946	FOOTHILLS AREAM		2 2 2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM CLIENT NOT ELICIBLE ON SERVICE				
3404946	FOOTHILLS AREAM ENTAL HEALT	21	2 2 2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM				
3404946		21	2 2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM CLIENT NOT ELICIBLE ON SERVICE				
3404946		21	2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM CLIENT NOT ELICIBLE ON SERVICE				
3404946		21	2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM CLIENT NOT ELICIBLE ON SERVICE	0		2040	0
3404946		21	2040	BENEFIT PACKAGE. DUPLICATE OF CLAIM-SYSTEM CLIENT NOT ELICIBLE ON SERVICE	0		2040	0

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		 		 	
NUMBER		EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENTALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
			ļ					ļ
3404957	TIDELAND MENTAL	79	416	THIS SERVICE IS NOT PAYABLE TO				
	HEALTH CTR		İ	YOUR SUBMITTED BILLING	İ			
				PROVIDER TYPE AND SPECIALTY IN				
		191	381	CLIENT ID NUMBER DOES NOT MATC	105	1303	2382	1079
				H PATIENT NAME				
		11	191	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
			T					
3404979	NEW RIVER AREAM	11	194	CLIENT NOT ELIGIBLE ON SERVICE				
	H/DD/SA PRO			DATE				
			T		I			
		21	14	DUPLICATE OF CLAIM-SYSTEM	1	227	608	381
		8599	14	DETAIL NOT COVERED BY COMBINAT				
			I	ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.	1			